State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

ROSS AND CASTILLO 744 E. Bullard Avenue Fresno, California 93710

OSHA Case No.

9 Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury / illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

A MAILING ADDRESS (Number and Street, City, ZIP) 2A. PHONE NUMBER 498-1574 2B. AUGATION CODE 3D. AL OCATION CODE 3D. AL	Age d yy) Daily hours of your Days per week ad?
O FUND: ORG: 4. NATURE OF BUSINESS MUNICIPALITY 6. TYPE OF EMPLOYER 9 PRIVATE 9 STATE CITY 9 COUNTY 9 SCHOOL DIST 7. EMPLOYEE NAME 10. HOME ADDRESS (Number and Street, City, ZIP) 11. SEX 12. OCCUPATION (Regular job title–NO initials, abbreviations or numbers) 5. STATE UNEMPLOYMENT INS. ACCT. NO. 944-0328 5. STATE UNEMPLOYMENT INS. ACCT. NO. 944-0328 5. STATE UNEMPLOYMENT INS. ACCT. NO. 944-0328 15. STATE UNEMPLOYMENT INS. ACCT. NO. 944-0328 16. TYPE OF EMPLOYEE NAME 17. EMPLOYEE NAME 18. SOCIAL SECURITY NUMBER 19. DATE OF BIRTH (mm decomposition) 10. A PHONE NUMBER 11. SEX 12. OCCUPATION (Regular job title–NO initials, abbreviations or numbers) 13. DATE OF HIRE (mm decompositions)	Industry Occupation Id yy) Sex Age d yy) Daily hours of your Days per week
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O 9 MALE 9 FEMALE	ed?
Y 14. EMPLOYEE USUALLY WORKS 14. EMPLOYMENT STATUS (check applicable status at time of injury) 14B. Under what class code policy were wages assigned policy were wages assigned.	
15. GROSS WAGES/SALARY 16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodgin	
\$ per _WEEK overtime, bonuses, etc.)? 9 YES \$ per : NO 17. DATE OF INJURY OR ONSET OF ILLNESS	
(mm dd yy)A.MP.MA.MP.M. (mm dd yy)	index, mage
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? 22. DATE LAST WORKED (mm dd yy) 23. DATE RETURNED TO WORK (mm dd yy) 24. IF STILL OFF WORK, CHECK THIS BOX.	9 County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? 26. SALARY BEING CONTINUED? 27. DATE OF EMPLOYER'S KNOWLEDGE 28. DATE EMPLOYEE WAS PROVIDE NOTICE OF INJURY/ILLNESS EMPLOYEE CLAIM FORM	D Nature of Injury
9 YES 9 NO 9 YES	
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning. N	Part of body
J 30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City) 30A. COUNTY 30B. ON EMPLOYER'S PREMISES? 9 YES 9	Source NO
R 31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop. 32. OTHER WORKERS INJURED/ILL EVENT? 9 YES 9	
O 33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED., e.g., acetylene, welding torch, farm tractor, scaffold.	Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.	Extent of Injury
S. HOW INJURY/ILLNESS OCCURRED DESCRIBE SEQUENCE OF EVENTS SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g. work to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld and burned right hand. USE SEPARATE SHEET IF NECESSARY. N E S C C S C S C S S S S S S S S S S S S	er stepped back
S 36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP) 36A. PHONE NUMBER	
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP) 37A. PHONE NUMBER	
Completed by (type or print) Signature Title	Date